

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/05/2012
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 3175 LANCER ST PORTAGE, IN 46368
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F0000	<p>This visit was for the Investigation of Complaints IN00118648 and IN00118883.</p> <p>Complaint IN00118648-Substantiated. Federal/state deficiencies related to the allegation are cited at F157, F282, F387, and F514.</p> <p>Complaint IN00118883-Substantiated. Federal/state deficiencies related to the allegations are cited at F309.</p> <p>Unrelated deficiencies cited.</p> <p>Survey dates: November 1, 2, & 5, 2012</p> <p>Facility number: 000098 Provider number: 155187 AIM number: 100290980</p> <p>Survey team: Janet Adams, RN, TC Amber Bloss, Medical Surveyor November 1 & 2, 2012</p> <p>Census bed type: SNF/NF: 169 Total: 169</p> <p>Census payor type:</p>	F0000	<p>Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>Medicare: 30 Medicaid: 123 Other: 16 Total: 169</p> <p>Sample: 11</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on November 9, 2012 by Bev Faulkner, RN</p>				

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F0157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on observation, record review, and interview, the facility failed to ensure the Physician and the resident's family member were notified of the resident's PEG tube being shortened for 1 of 3</p>	F0157	The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:	12/03/2012	

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	<p>residents with PEG (Percutaneous Endoscopic Gastrostomy) tubes in the sample of 11. (Resident #E)</p> <p>Findings include:</p> <p>During orientation tour on 11/1/12 at 9:45 a.m., LPN #1 indicated Resident #E was currently at the hospital for the replacement of a PEG feeding tube.</p> <p>On 11/2/12 at 8:15 a.m., LPN #1 was observed administering medications to Resident #E through the PEG tube. There was no drainage around the PEG tube site.</p> <p>The record for Resident #E was reviewed on 11/1/12 at 10:30 a.m. The resident's diagnoses included, but were not limited to, insomnia, diabetes mellitus, high blood pressure, and cerebrovascular disease.</p> <p>Review of the 9/12 Nurses' Notes indicated there was no documentation of the resident's PEG tube leaking or of any problems with the tube or the administration of the ordered tube feeding. There was no documentation of the resident's Physician or family being notified of any changes in the length of the PEG tube.</p>		<p>Resident E's family and physician were notified on the peg tube shortening.</p> <p>Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows:</p> <p>All residents with peg tubes have had their tubes assessed to ensure none had been shortened and none were found.</p> <p>The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows:</p> <p>Nurses were reeducated on notification of change and the Enteral tube guideline.</p> <p>Unit Managers will audit clinical records 5 x a week for 4 weeks and then monthly to ensure notification of change has been made.</p> <p>Unit Managers will assess all residents with peg tubes weekly x 4 weeks and then monthly for 6 months for ant care issues.</p>				

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	<p>Continued record review on 11/5/12 at 8:15 a.m., indicated a Hospital After Visit Summary" was completed on 11/1/12. The summary indicated the resident underwent PEG tube change procedure.</p> <p>Review of a Grievance Form, dated 9/6/12, indicated a concern about the resident's PEG tube being cut was left as a voice mail message. The voice mail grievance was first heard by the Director of Nursing at the time. The Nursing Unit Manager was assigned to investigate the grievance. The "nature of the resolution" section on the grievance form listed interviews with staff began and staff inservices were done.</p> <p>Review of the "meeting notes" from the attached inservice were reviewed. The Nursing staff members were inserviced on 9/12/12. The subjects covered in the inservice indicated nurses were not to cut a resident's G-tube (gastrostomy) tube for any reason. The inservice also indicated the Physician and family were to be called for any problems with G-tubes.</p> <p>The current facility policy titled "Notification of Change in Resident Health Status" was received from the facility Nurse Consultant on 11/5/12 at 10:00 a.m. There was no date on the</p>		<p>These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:</p> <p>DNS/Designee will report findings of audits to monthly QA meetings for 6 months, any patterns or trends will have an action plan written and interventions implemented.</p>		

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	<p>policy. The policy indicated the resident's Physician, Nurse Practitioner, or Physician Assistant, and if known will notify the resident's interested family member of the need to alter treatment.</p> <p>When interviewed on 11/2/12 at 10:05 a.m., the Unit Manager indicated they received a voice mail message from the Resident #E's family member indicating some staff members had cut the resident's PEG tube. The Unit Manager indicated she assessed the resident's PEG tube at that time and she noted the tube was "shorter" than previously seen. The Unit Manager indicated she interviewed staff and no staff member indicated they had cut the resident's PEG tube. The Unit Manager indicated she did not document the above assessment of the PEG tube.</p> <p>This federal tag relates to Complaint IN00118648.</p> <p>3.1-5(a)(3)</p>				

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F0282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, record review and interview, the facility failed to follow the resident plan of care related to ensuring two staff members were present when providing care for 1 of 1 resident reviewed for care plan interventions for two staff member to be present in the sample of 11. (Resident #E)</p> <p>Findings include:</p> <p>On 11/2/12 at 8:15 a.m., LPN #1 was observed administering medications to Resident #E through the PEG tube. There was no drainage around the tube site. The LPN also suctioned the resident's mouth and then provided oral care to the resident. There were no other staff members present in the room when the LPN was administering the medications or providing care to the resident.</p> <p>The record for Resident #E was reviewed on 11/1/12 at 10:30 a.m. The resident's diagnoses included, but were not limited to, insomnia, diabetes mellitus, high</p>	F0282	<p>The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:</p> <p>LPN#1 was reeducated regarding following the care plan and that 2 staff members are to be in Resident E's room while giving care.</p> <p>Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows:</p> <p>Care plans were reviewed and C.N.A. assignment sheets were updated as needed to ensure any resident requiring 2 staff members present during care was identified.</p> <p>Licensed staff was educated regarding following the care plan for 2 staff members present in rooms during care.</p> <p>The measures put into place and the systemic changes made to ensure that this</p>	12/03/2012

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	<p>blood pressure, and cerebrovascular disease.</p> <p>The resident's current care plans were reviewed. A care plan initiated on 8/16/11 indicated the resident had made allegations of being hit by a staff member. The care plan had target goal date of 11/30/12. A care plan intervention was initiated on 8/16/2011. The intervention indicated two staff members were to be present when care was provided. This intervention was last revised on 8/28/11.</p> <p>Review of a Incident, dated 10/22/12, indicated the resident's family member left a voicemail message indicating the resident informed her a nurse on the midnight shift called her a "(profanity) baby." The investigation included with the Incident report indicated two CNA's and one Nurse were interviewed. The summary and outcome section of the investigation indicated the Nurse was noted to be inside the resident's room and the two CNA's were noted to be outside of the resident's door.</p> <p>When interviewed on 11/5/12 at 8:00 a.m., the ADON (Assistant Director of Nursing) indicated she investigated the allegation. The ADON indicated the LPN named by the resident was in the resident's room without a second staff</p>		<p>deficient practice does not recur are as follows:</p> <p>Care plans were reviewed and C.N.A. care sheets were updated as needed to ensure any resident requiring 2 staff members present during care was identified.</p> <p>Licensed staff was educated regarding following the care plan for 2 staff members present in rooms during care.</p> <p>DNS/Designee will audit licensed staff during care 5 x a week for 4 weeks, the 3 x a week for 4 weeks, then monthly on different shifts.</p> <p>These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:</p> <p>DNS/Designee will report findings of audits to monthly QA meetings for 6 months, any patterns or trends will have an action plan written and interventions implemented.</p>		

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	<p>member as required per the resident's care plan.</p> <p>This federal tag relates to Complaint IN00118648.</p> <p>3.1-35(g)(2)</p>			

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F0309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, record review, and interview, the facility failed to ensure the correct treatment was completed to a leg wound for 1 of 3 residents reviewed for leg wounds in the sample of 11. (Resident #D)</p> <p>Finding include:</p> <p>On 11/1/12 at 1:50 p.m., RN#1 was observed completing care to a wound on Resident #D's left ankle. The RN removed a clear transparent dressing from the resident's left ankle. There was a 1 cm (centimeter) round open wound noted on the ankle. The RN cleansed the area with soap and water and applied a Prisma octangular shaped dressing over the open area. The dressing was approximately 3 cm x 3 cm and covered the wound and the surrounding tissue. The RN then applied a Medipore white tape dressing over the area. RN #1 did not wrap a Kerlix dressing around the wound.</p> <p>The record for Resident #D was reviewed</p>	F0309	<p>The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows: Resident D was assessed to ensure that there was no negative effect from using the wrong treatment. None was found. Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows: Residents receiving treatments were assessed to ensure that the correct treatment had been completed. The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows: RN#1 was educated on following the physician's order and the clean dressing change procedure. The education included return demonstration Wound care nurse/Designee will audit different licensed staff on clean dressing change audits weekly for 4 weeks and then monthly.</p>	12/03/2012	

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	<p>on 11/2/12 at 1:30 p.m. The resident's diagnoses included, but were not limited to, cellulitis of the left foot, gout, peripheral vascular disease, anemia, high blood pressure, and diabetes mellitus.</p> <p>Review of the 10/11/12 "Wound Care Clinic Discharge Summary" indicated staff were to cleanse the wound every two days and apply foam (Prisma then foam) and then dress with a gauze roll. The instructions also included a "NOTE" which indicated the resident had the foam with him and staff were to please follow how it was done at the Wound Clinic to prevent maceration (softening or breaking down of tissue from constant dampness which can be caused by exposure to perspiration, urine, or wound exudate).</p> <p>Review of the 10/12 Physician orders indicated an order was written on 10/11/12 to clean the wound daily with mild soap and water, loosely pack wound bed with Prisma and redress with Tegaderm Foam, as directed.</p> <p>When interviewed on 11/2/12 at 10:15 a.m., the Wound Nurse indicated the resident had a wound to the left ankle area and was being seen at the Wound Clinic. The Wound Nurse indicated the current treatment was to wash the area and then apply a Prisma dressing and then cover</p>		<p>Licensed staff will be audited by 12/3/12. These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:</p> <p>DNS/Designee will report findings of audits to monthly QA meetings for 6 months, any patterns or trends will have an action plan written and interventions implemented.</p>		

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	<p>with a piece of foam. The Wound Nurse indicated the Prisma is to be applied over the open wound and when the dressing becomes moistened with any exudate it then transforms to gel and absorbs the exudate. The Wound Nurse indicated the resident had returned from the Wound Clinic with foam that was to be used and this foam was in the resident's room.</p> <p>The Wound Nurse obtained the package of the foam from the resident's room at this time. This foam was not used on 11/1/12 when RN#1 completed the treatment. The Wound Nurse indicated this was the foam to be used over the Prisma dressing to the foot wound.</p> <p>When interviewed on 11/5/12 at 9:15 a.m., the Wound Nurse indicated the foam from the Wound Clinic was called "Tegaderm Foam."</p> <p>This federal tag relates to Complaint IN00118883.</p> <p>3.1-37(a)</p>				

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F0323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review and interview, the facility failed to ensure adequate supervision was provided for a cognitively impaired resident with a history of wandering into other resident rooms and laying in other resident beds for 1 of 2 residents reviewed for supervision related to wandering behaviors in the sample of 11. (Residents #K and #L)</p> <p>Findings include:</p> <p>Observation during orientation tour on 11/1/12 at 9:20 a.m., indicated Resident #K's room was across from Resident's #L's room.</p> <p>The record for Resident #K was reviewed on 11/2/12 at 10:30 a.m. The resident's diagnoses included, but were not limited to, depressive disorder, anxiety state, psychosis, vascular dementia, and congestive heart failure.</p> <p>The 8/17/12 Minimum Data Set (MDS) quarterly assessment indicated the</p>	F0323	<p>The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:</p> <p>Resident K was immediately removed from Resident L's room. We placed an alarms on Resident K's wheelchair. We notified the both families and their doctors. The alarm will notify staff that she got up and may be going to the wrong bed. We then notified the state. Both families were satisfied with our actions.</p> <p>Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows:</p> <p>Any resident that has a recent history of wandering had charts and care plans reviewed by IDT and any modifications of interventions were completed and the C.N.A care sheets were updated as indicated.</p>	12/03/2012			

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	<p>resident BIMS (Brief Interview for Mental Status) score was 3. This indicated the resident's cognitive patterns were severely impaired. The assessment indicated the resident required assistance of staff for transfers.</p> <p>Review of a 11/1/12 "Verification of Investigation" report indicated the resident was found naked from the waist down with a male resident (Resident #L). The residents were in the bed of the male resident's room mate. The resident had no apparent injuries. The resident was assessed by a nurse and no signs of penetration were observed. The resident denied pain and had no signs of bruising or bleeding noted. The report also indicated it appeared the male resident had ejaculated.</p> <p>Resident #K's current care plans were reviewed. A care plan initiated on 5/30/12 indicated the resident was at risk for elopement, exit seeking, and attempting to exit. The care plan was last updated with a target goal date of 11/30/12. Care plan interventions included to talk to the resident to find out what she is looking for. The care plan did not address interventions to related to the residents history of putting herself into other resident's beds. There was no identified plan in place to alert staff to the</p>		<p>The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows:</p> <p>Staff educated on supervising residents with a history of wandering into other resident's rooms. Staff reeducated on reviewing the C.N.A care sheets that identify residents that wander.</p> <p>DNS/Designee will audit CNA care sheets 3 x a week for 4 weeks, then weekly for 4 weeks and then monthly.</p> <p>These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:</p> <p>DNS/Designee will report findings of audits to monthly QA meetings for 6 months, any patterns or trends will have an action plan written and interventions implemented.</p>				

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	<p>resident's history of placing herself in other resident's beds. Review of the resident's "resolved" care plans provided by the facility did not indicated the resident's behavior of the resident putting herself into other resident beds as reported by the staff.</p> <p>The "Resident Care Plan Sheet" at the Nurses' Station was reviewed. The sheets included information including safety concerns, assistive devices needed, and special needs for each resident on the unit. There was also a section for miscellaneous information pertinent to each resident. There was no documentation under Resident K's name indicating she had a history of getting into other resident's beds.</p> <p>The record for Resident #L was reviewed on 11/2/12 at 10:50 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus, dementia, high blood pressure, and cerebrovascular disease.</p> <p>Review of the 8/27/12 Minimum Data Set (MDS) quarterly assessment indicated the BIMS (Brief Interview for Mental Status) score was 5. This indicated the resident's cognitive patterns were severely impaired. The assessment also indicated the resident required assistance of staff for dressing,</p>			

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	<p>transfers, and personal hygiene.</p> <p>Review of a 11/1/12 "Verification of Investigation" report for Resident #L indicated the resident was found in bed with another resident. The resident was naked and fully erected and no injury was observed.</p> <p>When interviewed on 11/2/12 at 10:40 a.m., the interim DON (Director of Nursing) indicated she received a call from the nursing staff at approximately 7:45 p.m., on 11/1/12. The interim DON indicated she was informed Resident #K was observed in bed with another Resident #L. The interim DON indicated Resident #K had a history of getting into different room and beds. The DON indicated the resident was able to transfer herself into the bed. The resident was assessed and no injuries were noted. The interim DON indicated she was informed there was evidence of ejaculation. Resident #K did not have any signs if injury.</p> <p>When interviewed further on 11/2/12 at 11:15 a.m., the interim DON indicated she spoke with staff on the phone on 11/1/12. She indicated the residents were both in Resident #L's room mate's bed. The DON indicated she spoke with the Nurse on duty at the time the resident's</p>			

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	<p>were found in bed and it was reported there was semen on the bed but there was no semen on Resident #K. The DON indicated the two residents were placed on 30 minute checks after the event.</p> <p>When interviewed on 11/2/12 at 1:15 p.m., the Social Worker indicated both Resident #K and Resident #L were cognitively impaired. The Social Worker indicated she did not feel Resident #K would know her room number or location. The Social Worker indicated she thought Resident #L would be able to find his room on his own. The Social Worker indicated the resident's wife had lived at the facility in the past and she was discharged home approximately a year ago and the resident has a wanderguard on then due to making statements about wanting to leave. The Social Worker indicated the Resident #K had exhibited exit seeking when she was first admitted and had a wanderguard on then. The Social Worker indicated the wanderguard had been discontinued approximately a week ago. The Social Worker indicated she was "not 100 % " sure but she did believe the Unit Manager had mentioned Resident #K having been in another resident's bed in the past. The Social Worker indicated she was informed of the 11/1/12 incident involving Residents #K and #L earlier this morning.</p>			

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	<p>When interviewed on 11/2/12 at 1:20 p.m., the Nursing Unit Manager indicated Resident #K was transferred to this unit from the Dementia unit after having surgery. The Unit Manager indicated the resident had a history of putting herself into other resident's beds.</p> <p>3.1-45(a)(2)</p>			

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F0387 SS=D	<p>483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT</p> <p>The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.</p> <p>A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.</p> <p>Based on record review and interview, the facility to ensure residents were seen by the Physician at least once every 60 days as required for 2 of 3 residents reviewed for required Physician visits. (Residents #E and #L)</p> <p>Findings include:</p> <p>1. The record for Resident #E was reviewed on 11/1/12 at 10:30 a.m. The resident's diagnoses included, but were not limited to, insomnia, diabetes mellitus, high blood pressure, and cerebrovascular disease. The resident was admitted to the facility in 2011.</p> <p>Physician Progress Notes indicated recent Physician visits were made on 10/30/12, 10/22/12, and 9/7/12. Prior to 9/7/12 the last Physician visit Progress Note was completed on 4/17/12.</p> <p>When interviewed on 11/2/12 at 2:00 p.m., the Unit Manager indicated no other</p>	F0387	<p>The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:</p> <p>Physician for Resident E and L was contacted and came to facility and saw Resident E on October 30, 2012 and Resident L on October 25, 2012. Resident E also saw her Neurologist on October 15, 2012. Progress notes were written for all visits.</p> <p>Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows:</p> <p>Residents were audited to ensure that timely physician visits had occurred and no other residents were out of compliance.</p>	12/03/2012	

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	<p>progress notes could be provided to verify the required visits.</p> <p>2. The record for Resident #L was reviewed on 11/2/12 at 12:00 p.m. The resident's diagnoses included, but were not limited to, diabetes, cerebrovascular disease, renal failure, and dementia. The resident was admitted to the facility in 2010.</p> <p>Physician Progress Notes indicated Physician visits were made on 9/28/12 and 5/6/12. There were no Physician visit Progress Notes between 5/6/12 and 9/28/12.</p> <p>This Federal tag relates to Complaint IN00118648.</p> <p>3.1-22(d)(1)</p>		<p>The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows:</p> <p>Health information manager will track physician compliance with visits. Health information manager will send reminder letters as needed to any MD who is nearing the required due date for a visit.</p> <p>The Health information manger will notify the ED of any physician who has not made a visit by the required due date. The ED will contact the physician and notify to see resident before the 10 day grace period.</p> <p>These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:</p> <p>DNS/Designee/Health Information Manager will report findings of audits of physician visits to monthly QA meetings for 6 months, any patterns or trends will have an action plan written and interventions implemented.</p>		

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F0514 SS=D	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on observation, record review and interview, the facility failed to maintain complete and accurate clinical records related to PEG (Percutaneous Endoscopic Gastrostomy) tube changes for 1 of 3 resident reviewed for PEG tubes in the sample of 11. (Resident #E)</p> <p>Findings include:</p> <p>During orientation tour on 11/1/12 at 9:45 a.m., LPN #1 indicated Resident #E was currently out at the hospital to have her PEG tube changed.</p> <p>On 11/2/12 at 8:15 a.m., LPN #1 was observed administering medications to the resident through the PEG tube. There was no drainage around the tube site.</p>	F0514	<p>The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:</p> <p>Resident E had peg tube changed on 11.1.2012.</p> <p>Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows:</p> <p>Other residents with peg tubes were assessed and had charts reviewed to ensure any issues with their peg tube was documented.</p> <p>The measures put into place and the systemic changes</p>	12/03/2012			

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	<p>The record for Resident #E was reviewed on 11/1/12 at 10:30 a.m. The resident's diagnoses included, but were not limited to, insomnia, diabetes mellitus, high blood pressure, and cerebrovascular disease.</p> <p>Review of the 9/12 Nurses' Notes indicated there was no documentation of the resident's PEG tube leaking or of any problems with the tube or the administration of the ordered tube feeding.</p> <p>Continued record review on 11/5/12 at 8:15 a.m., indicated a "Hospital After Visit Summary" was completed on 11/1/12. The summary indicated the resident underwent PEG tube change procedure.</p> <p>Review of a Grievance Form, dated 9/6/12, indicated a concern about the resident's PEG tube being cut was left as a voice mail message. The voice mail grievance was first heard by the Director of Nursing at the time. The Nursing Unit Manager was assigned to investigate the grievance. The "nature of the resolution" section on the grievance form listed interviews with staff began and staff inservices were done.</p>		<p>made to ensure that this deficient practice does not recur are as follow</p> <p>Licensed staff was educated on documentation regarding peg tubes.</p> <p>Unit Managers will assess all residents with peg tubes weekly x 4 weeks and then monthly for 6 months for ant care issues and that any issues are documented.</p> <p>These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:</p> <p>DNS/Designee will report findings of audits to monthly QA meetings for 6 months, any patterns or trends will have an action plan written and interventions implemented.</p>				

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	<p>Review of the "meeting notes" from the attached inservice were reviewed. The nursing staff members were inserviced on 9/12/12. The subjects covered in the inservice indicated nurses were not to cut a resident's G-tube (gastrostomy) tube for any reason. The inservice also indicated the Physician and family were to be called for any problems with G-tubes.</p> <p>The current policy titled "G-Tube Guidelines" was received from the Nurse Consultant on 11/5/12 at 10:00 a.m. The policy had a revised date of January 2011. The policy indicated the recommendation is not to routinely replace G-tubes. There was no documentation regarding interventions of shortening the tubes.</p> <p>When interviewed on 11/2/12 at 10:05 a.m., the Unit Manager indicated they received a voice mail message from the Resident #E's family member indicating some staff members had cut the resident's PEG tube. The Unit Manager indicated she interviewed staff and the staff interviewed denied having cut the PEG tube. The Unit Manager indicated she assessed the resident's PEG tube and noted the tube was "shorter" than previously observed. The Unit Manager indicated she did not document the above assessment of the PEG tube. The Unit Manager indicated there was no</p>			

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	<p>documentation of any problems with the tube or of the tube being shorter.</p> <p>This federal tag relates to Complaint IN00118648.</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p>			